PROMISING PRACTICES IN HOME AND COMMUNITY-BASED SERVICES

California – The Village Integrated Service Agency

Issue: Comprehensive, Individualized Services for People with Serious Mental Illnesses through a Single Provider

Summary

The Village Integrated Service Agency, a comprehensive, non-residential program operated by the National Mental Health Association of Greater Los Angeles, combines multiple mental health care services to encourage people with serious mental illness to achieve self-sufficiency. The Village tailors its services to an individual's mental health needs and has become a national model and training ground. Evaluations of the Village have shown increases in the percentage of people attempting paid employment and reductions in psychiatric hospitalization and incarceration.

Introduction

The Village Integrated Service Agency ("the Village"), a program of the non-profit National Mental Health Association of Greater Los Angeles, provides coordinated, comprehensive services for people with serious mental illness in the community. Utilizing a person-centered philosophy, the Village creates a "personal service plan" for each of its consumers (which the Village calls "members"). The Village staff help each member select from a menu of psychiatric, employment, housing, health, financial and recreation options.

The Village helps each person develop a customized service plan.

This report briefly describes The Village, its origins, and evidence of its effectiveness in helping people with mental illness live independently. This report is based on interviews with Village staff, documents from the National Mental Health Association of Greater Los Angeles, and an article from the November 2000 issue of *Psychiatric Services*.

Background

Located in Long Beach, California, the Village began in April 1990 as a three-year pilot funded by the California Department of Mental Health using state general revenue. California also funded two additional Integrated Service Agency demonstrations: a countywide project in Ventura County and a rural project in Stanislaus County. The pilots designed and tested innovative delivery systems to provide all mental health-related services in a way that avoids the common fragmentation between multiple services and funding sources.

After its pilot phase, the Village continued its program with a grant from Los Angeles County. The Village also billed Medicaid for services that met California's definition of rehabilitation services in the Medicaid state plan such as individual and group therapy and medication support services. Additional funding in fiscal year 1996-97 enabled the Village to expand from its original 113 members to 276 adults with serious mental illness.

The Village expanded again after the California legislature approved Assembly Bill 34 (AB 34) in 1999. The law authorized $10 million for one-year demonstration grants to treat people with serious mental illness who were homeless or who were on probation or parole. The Village was one of the 17 pilot programs in three pilot counties (Los Angeles, Stanislaus, and Sacramento). A second law, Assembly Bill 2034 (AB 2034), expanded the grants after the pilot programs demonstrated cost effectiveness and

improvements in participant outcomes. In state fiscal year 2002-2003, AB 2034 programs served 4,881 people and operated in 34 of the state's 58 counties. The grant, along with continued Medicaid billing, allowed the Village to expand to 473 members.

Intervention

The Village uses a person-centered, recovery philosophy, which is different from many programs for people with mental illness. Village staff focus on establishing collaborative relationships with members by treating the members as equal partners in determining the services they receive. Staff establish adult-to-adult interactions with members, encourage members to try new things, and help members overcome a common fear of failure. The Village provides supportive services both on site and in the community, depending on the participant's preference.

The Village services are built around multidisciplinary teams. Each team is comprised of a team leader and several personal service coordinators including a licensed social worker, a registered nurse, psychiatric technicians, and unlicensed staff. The personal service coordinators help members identify and pursue their goals by providing direct services and by helping members to access outside services. While each member has a particular personal service coordinator, the coordinators integrate services so members can benefit from the team's multidisciplinary skills.

Service coordinators help people identify and pursue quality of life goals.

Each team has both fiscal and clinical responsibility. The Village gives teams the authority to make spending decisions to support their members. The service teams reflect the Village's emphasis on psychosocial rehabilitation and community integration by allocating more resources to employment and community support activities and fewer resources to clinical treatment and hospital services.

Psychiatrists and resource specialists in housing, employment, community integration, money management, and substance abuse complement the teams. Originally, each team worked with a part-time psychiatrist, and other specialists served all of the Village's membership. The agency served 100 – 200 people and was small enough for specialists to know each person, just as the team staff knew each person on their team. This familiarity allowed the Village to function as a friendly community.

Now, the Village's facility is organized into five "neighborhoods," each with a physically distinct space. The three main neighborhoods serve 115-130 members and are small enough to maintain the community atmosphere of the original, smaller Village. In addition, two smaller neighborhoods serve transitional age youth (ages 17 – 25) and provide short-term services such as: accessing dual diagnosis or drug or alcohol detox, immediate housing assistance, and medication re-evaluation for homeless individuals who need assistance but may not qualify for the entire program. Each neighborhood has a full-time psychiatrist and full-time resource specialists in community integration and money management. Specialists in job development, substance abuse recovery, and housing are still available for Village members, but operate separately from the neighborhoods. The Village also has a 24-hour-a-day hotline so a participant can call in an emergency.

Implementation

Village staff report the greatest challenge in starting and operating the Village was the extreme "culture shift" required of both staff and members; the transition from a symptom reduction philosophy to a recovery philosophy. The program faces difficulty finding staff trained in the principles of assertive community treatment (ACT) and psychosocial rehabilitation – the two approaches that form the foundation of the Village's service philosophy. This is an ongoing challenge as new staff join the Village, and management invests significant resources into training staff on these models.

Similarly, many members who previously had been treated primarily in institutional and day treatment settings find it difficult when their personal service coordinator first asks about "non-illness-based" goals, such as finding employment, improving their social lives, or moving into their own apartment. Some members found it frightening to take responsibility for their own achievements and failures. Over time, however, program staff said this approach enhances feelings of empowerment for both members and staff.

The National Mental Health Association of Greater Los Angeles (MHA-LA), the Village's parent organization, has experience informing other communities about the integrated service model and helping them to make the "culture shift". In 1991, MHA-LA started training and consultation services to promote the model. MHA-LA has trained system planners, service providers, and people with mental illness and their families from across the nation and around the globe. The model also informed the development of many AB 2034 programs across California that serve people with serious mental illness. Over 600 staff from AB 2034 agencies have received a three-day intensive training program at the Village to experience the model.

Impact

Lewin-VHI, Inc. evaluated the Village for the three-year pilot period (1990-1993). Lewin compared Village members to a randomly selected comparison group receiving typical treatment services. During the pilot, 73 percent of Village members attempted paid employment compared to 15 percent of the comparison group. Also, the average annual psychiatric hospitalization cost for Village members was one-third the average cost for the comparison group, although there was no significant difference between the percentages of members who used inpatient services. One factor in the reduced hospitalization costs was that Village psychiatrists had hospital admitting and discharging privileges and were therefore able to provide a greater continuity of care.

More recent program data also indicate positive outcomes. An evaluation of the seventeen AB 34 pilot programs, including the Village, compared AB 34 participants' incarceration data for the twelve months before and after enrollment. The number of incarceration days for AB 34 participants was reduced by 81 percent. The Village was the largest of the AB 34 pilots and its members achieved an 80 percent reduction in incarceration days.

The Village has also implemented its own outcomes evaluation system. In January 2004, 72 percent of members lived independently or with family members and 14 percent of members performed paid employment. Employment opportunities ranged from part-time, supported, minimum wage jobs through full-time, competitive, higher-paid jobs.

Contact Information

For more information about the Village, please contact Martha Long at 562-437-6717 Ext. 252 or marthalong@village-isa.org. Information about the Village is available on the Internet at http://www.village-isa.org.

Some Discussion Questions:

Can the culture shift achieved at the Village be achieved consistently without integrated service delivery?

How can this model be adapted to rural areas where the multidisciplinary teams must serve fewer people or a much larger geographic area?

The original report was written by Amy Leventhal Stern, Ph.D. Medstat revised this report, which is one of a series of reports by Medstat for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series is available online at CMS' Web site, http://www.cms.hhs.gov/promisingpractices/. This report is intended to share information about different approaches to offering home and community-based services. This report is not an endorsement of any practice.